Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
CLINICS OF NORTH TEXAS

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

MFDR Tracking Number
M4-14-0542-01

Carrier's Austin Representative
Box Number: 45

MFDR Date Received
OCTOBER 15, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position summary with the request for medical fee dispute resolution.

Amount in Dispute: $329.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In review of the dispute packet submitted by the requestor Clinics of North Texas, the Office performed an in-depth review of the requestor's billing and determined that we will maintain our denial for 29-Time limit for filing has expired. The requestor submitted evidence of a P2P E-Bill status report that shows the status as 'Print and Mail', however there is no information included with this report that supports the bill was in fact mailed to the carrier. Unfortunately the requestor's clearinghouse report is not sufficient evidence that the provider's bill was in fact 'sent' or received by the carrier within 95 days from date of service. A review of our bill tracing system did not locate a bill being received prior to our receipt of the 1/24/2013 submission of the aforementioned date of service (Exhibit A). The Office respectfully requests the Division deem the dates of services 10/15/2012 referenced above ineligible for medical dispute resolution pursuant to §Rule 133.307 (f)(3)(A)as [sic] the requestor has failed to submit to the Office a request for reconsideration pursuant to §Rule 133.250."

Response Submitted by: STATE OFFICE OF RISK MANAGEMENT

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 15, 2012	CPT Codes 99203-25 & 99080 HCPCS Code L1830	$329.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.

3. 28 Texas Administrative Code §133.250 sets out the procedures for health care providers to request reconsideration.
4. 28 Texas Administrative Code §102.4 sets out the rules for non-Commission communications.
5. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
6. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 29 – The time limit for filing has expired.

Issues

1. Is the timely filing deadline applicable to the medical bills for the services in dispute?
2. Did the requestor forfeit the right to reimbursement for the services in dispute?
3. Did the requestor request reconsideration from the respondent?

Findings

1. 28 Texas Administrative Code §133.20(b) states, in pertinent part, that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided. In accordance with subsection (c) of the statute, the health care provider shall submit the medical bill to the correct workers' compensation insurance carrier not later than the 95th day after the date the health care provider is notified of the health care provider's erroneous submission of the medical bill. A health care provider who submits a medical bill to the correct workers' compensation insurance carrier shall include a copy of the original medical bill submitted, a copy of the explanation of benefits (EOB) if available, and sufficient documentation to support why one or more of the exceptions for untimely submission of a medical bill under §408.0272 should be applied..." Review of the documentation submitted by the requestor finds no convincing documentation was found to support that any of the exceptions described in Texas Labor Code §408.0272 apply to the services in this dispute. The respondent in this dispute submitted an AFFIDAVIT OF NON-EXISTENCE OF BUSINESS RECORD documenting that there was no record of a medical bill received prior to January 24, 2013 for date of service October 15, 2012. This was a signed and notarized document. Therefore, no convincing documentation was found to support the services in this dispute were submitted timely.
2. Texas Labor Code §408.027(a) states, in pertinent part, that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment." 28 Texas Administrative Code §102.4(h) states that "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday." Review of the submitted information finds no documentation to support that a medical bill was submitted within 95 days from the date the services were provided. Therefore, pursuant to Texas Labor Code §408.027(a), the requestor in this medical fee dispute has forfeited the right to reimbursement due to untimely submission of the medical bill for the services in dispute.
3. 28 Texas Administrative Code §133.307(f)(2) states: "The division may raise issues in the MFDR process when it determines such an action to be appropriate to administer the dispute process consistent with the provisions of the Labor Code and division rules." Review of the documentation submitted by the requestor finds that the requestor did not sufficiently document that a request for reimbursement was made in accordance with 28 Texas Administrative Code §133.250. Therefore, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		June 4, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.